COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

9 POINT COD SUBSTANCE ABUSE TREATMENT MODULE IN MENTAL HEALTH CLINICS

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INTRODUCTION

Addressing co-occurring substance abuse is of critical importance to the Los Angeles County Department of Mental Health (DMH). Overriding reasons are:

1. 50% of DMH clients have co-occurring substance abuse
2. Literature suggests that mental health treatment is ineffective unless co-occurring substance abuse is detected and treated in an integrated framework.

The purpose of the 9 point module is to more fully institute important aspects of integrated treatment in DMH clinics in an accelerated fashion. These aspects are detection, motivation for treatment, monitoring, and referral to substance abuse treatment systems. There is a good foundation to build upon.

1. With the Director's leadership, awareness of substance abuse treatment and the obligation to treat it has been the subject of extensive training and significant infrastructure building over the last few years.
2. The fine work of the community-wide committees for development of treatment systems at AFH pointed the way to specific interventions in the DMH system.
3. The Statewide COD Workgroup created a framework for integrated treatment in local mental health systems.

The 9 point COD module has five critical features:

1. Mental health clinicians with current skill sets can implement it.
2. It provides a way to deliver initial COD services in a fashion that promotes reimbursement.
3. It can be monitored and expanded efficiently.
4. It can guide training.
5. It can be implemented quickly.

OVERVIEW OF 9 POINT COD MODULE

1. **Initial Assessment:** Use the Supplemental COD Assessment Checklist and narrative as appropriate to document assessment components.
2. **Treatment Planning:** Use the Supplemental COD Treatment Planning Checklist and include substance abuse cessation as a component of all treatment plans for individuals with co-occurring substance abuse that exacerbates mental health-related problems.
3. **Counseling for substance abuse:** Counsel all clients regarding substance abuse, using principles derived from motivational enhancement interviewing.
4. **Counsel caregivers and family:** Counsel family about the positive roles that they can play in client recovery from substance abuse.
5. **Healthy living groups**: Refer and encourage attendance of all clients for whom substance abuse is identified as a current problem in healthy living groups. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** Consider detoxification regimens (valproate, benzodiazepines, clonidine), antirelapse/anticraving drugs (e.g., disulfiram, naltrexone, bupropion).
7. **Ongoing assessment:** Elicit information on cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** Link all clients and caregivers to appropriate 12-step programs and substance recovery programs, as well as other specialized social support services.
9. **Documentation:** Include supplementary COD checklists in the tabbed "Substance Abuse" section in all new charts and current charts where substance abuse is identified.

9 POINT COD MODULE: Initial Assessment

Initial Assessment: Use the Supplemental COD Assessment Checklist and narrative as appropriate to document the following assessment components:

1. **Abused substances:** Assess for abuse/nonabuse of: tobacco, alcohol, marijuana, inhalants, cocaine, psychostimulants, opioids, other

2. **Triggers:** Assess triggers

3. **Substance Funding**: Determine payment source for substances: benefits, reimbursement from high-risk activities

4. **Motivation for change:** Determine the hoped-for results of cessation of substance abuse.

5. **Caregiver role in substance abuse:** Determine the current role of caregivers in facilitating and/or decreasing substance abuse.

6. **Consequences:** Determine the adverse results to the client of substance abuse.

7. **Current substance abuse treatment:** Determine current treatment in mental health, alcohol and drug, and self-help programs.

9 POINT COD MODULE: Treatment Planning

Treatment Planning: Use the Supplemental COD Treatment Planning Checklist and include eventual substance abuse cessation in all treatment plans for individuals with co-ocurring substance abuse that exacerbates mental health-related problems.

- For polysubstance abuse, focus intervention on general substance abuse and one substance causing most serious mental health-related problems for client
- Use the Supplemental COD Treatment Planning Checklist to include specific problems, goals, and interventions in a manner that indicates the relationship of the client's substance abuse to other mental illness.

1. Document substance-related problem(s):

1. Substance-induced exacerbation (or cause) of symptoms of mental health condition
2. Substance-induced noncompliance with mental health treatment (readiness)
3. Substance-induced adverse effects on treatment of mental health condition
4. Other

2. Document substance-related goal(s):

1. Complete detoxification
2. Decrease substance abuse
3. Stabilize personal network
4. Decrease substance abuse-associated mental health problems
5. Increase safety of mental health interventions (e.g., medications)

3. Document substance-related intervention(s):

1. Interventions for physical and psychological security (housing, safe haven)
2. Linkage to substance abuse programs, sponsor
3. Engagement with substance abuse programs, 12-step groups, sponsor
4. Enroll in healthy living group to build skills for making and sustaining choices that alleviate impairments caused by mental illness and substance abuse.
5. Medication to decrease symptoms of substance withdrawal (detoxification)
6. Medication to decrease craving for substances
7. Motivational interviewing to decrease substance abuse
8. Counseling on strategies to avoid substance abuse
9. Education regarding substances

9 POINT COD MODULE: Counseling Clients and Caregivers

Counseling for substance abuse: Counsel all clients regarding substance abuse, using the following techniques.

- ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use
- ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
- ***Show optimism and affirmation:*** stories of treatment success, encouragement
- ***Give directed feedback:*** assessment of problems, personalized feedback, values and decisions pros and cons, change plan & options menu
- ***Address discrepancies*** between client goals and current behavior,
- ***Ask open-ended questions about substance abuse and consequences***
- ***Show reflected listening about substance abuse.***
- ***Give information about substance abuse patterns and principles of treatment***
- ***Give advice:*** Don't use, or cut down as much as possible to improve health, avoid trigger and high-risk situations, don't waste money on substance abuse.
- ***Review options:*** Abstinence is ultimate goal. Consider relevant pharmacological approaches to detoxification, replacement, antirelapse, and anticraving).
- ***Instill responsibility.*** Emphasize the role of choice.
- ***Elicited talk of decreasing substance use***
- ***Give anti-drug abuse literature***

Counsel caregivers and family:

- Discuss importance of recovery to both client and loved ones
- Develop and support plans for decreasing triggers for client
- Develop and support plans for decreasing client access to substances
- Develop and support plans for decreasing contingency reinforcement of substance abuse
- Develop and support plans for decreasing other forms of enabling
- Give Alanon literature and contact information

9 POINT COD MODULE: Documentation

- Include tabbed “Substance Abuse” section in all new charts and current charts where substance abuse is identified.
- Within section include: Supplemental COD Assessment Checklist, Supplemental COD Treatment Planning Checklist, Linkage Record, and Supplemental COD Reassessment Form Checklist. Reassessment Checklist should be completed at each visit or monthly, whichever is the shorter interval.
- Documentation should be consistent with all departmental policies and guidelines.
- Program review should include chart review for presence of above

Cigarettes > 1 PPD

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document average PPD
    - Triggers: Common triggers for COD-related cigarette smoking include psychological stress, proximity to users, desire for companionship, and avoidance of nicotine withdrawal symptoms.
    - Substance payment sources: Common payment sources for COD-cigarette smoking include disability benefits, legal income/allowance, and supplies from friends.
    - Motivations for change: Common motivations for COD-related cigarette smoking include improving pulmonary and general health status and saving money.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related cigarette use include supplying cigarettes or money for purchase, tolerating presence of cigarettes in the residential setting, and using cigarettes with client.
    - Adverse consequences to client of cigarette abuse: Common adverse consequences to clients from cigarette abuse include general health problems and financial distress.
    - Current cigarette abuse treatments or self-help: Common treatment attempts in COD-related cigarette use include attempts to stop independently and use of over-the-counter nicotine replacement therapy.

2. **Treatment Planning:** Include substance abuse cessation in all treatment plans for individuals with co-ocurring substance abuse.
    - Cigarette abuse in most cases may not be directly related to a mental health problem. It is therefore not likely to be a focus of treatment in outpatient mental health clinics, beyond general educational interventions and healthy living groups.

3. **Counseling for cigarette abuse:**
    - ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
        - For COD-related cigarette smoking, this interpersonal relationship is compromised by therapist references, verbal or visual, to the therapist's own current use of cigarettes.
    - ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
        - Motivation often includes discussion of adverse health consequences to self and others via fire danger and second hand smoke and economic cost of cigarettes.

- ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement
    - The past history of multiple failed attempts to stop smoking prior to successful smoking cessation in most individuals should be emphasized for clients who have attempted to stop smoking in the past.
- ***Give directed feedback:***
    - Feedback for COD-related cigarette abuse should include assessment of triggers and discussion of general health risks and economic costs.
- ***Ask open-ended questions***
- ***Show reflected listening***
- ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related cigarette abuse information should include discussion of high prevalence of cigarette abuse in individuals taking antipsychotic medication, the effect of cigarette smoking on metabolism of antipsychotic medications, the fire-related dangers of smoking in group residential settings, and the advisability of eliminating cigarettes from the immediate residential environment.
- ***Give advice:*** COD-related cigarette abuse advice should be to attempt to decrease use of cigarettes due to potential general health-related problems, financial cost, and potential effects of nicotine on metabolism of prescribed medications.
- ***Review options:*** Consider gradual reduction in intensity of cigarette abuse, smoking cessation groups, nicotine replacement therapies, and bupropion.
- ***Instill responsibility.*** Emphasize the role of choice in avoiding long term health consequences to self and to others via dangers of fire and second-hand smoke.
- ***Elicited talk of decreasing cigarette use***
- ***Give cigarette abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related cigarette abuse should emphasize
    - Importance of smoking cessation to both client and loved ones
    - Decreasing triggers for client, including use of cigarettes by associates, supplying cigarettes, and tolerating smoking within residential setting.
    - Decreasing client access to cigarettes: Removing cigarettes from residential setting should be emphasized.
    - Decreasing contingency reinforcement of cigarette abuse, including supplying cigarettes as a reward, or providing companionship during smoking activities.
    - Decreasing other forms of enabling, including funding of cigarette purchases.
    - Give Alanon literature and contact information

5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** Consider bupropion for anticraving treatment.
7. **Ongoing assessment:** Elicit information on cigarette cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on available smoking cessation programs.
9. **Documentation:** Program review should include chart review for presence of above

Alcohol Abuse > 2 oz alcohol/day

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document average ounces of alcohol/day. One oz alcohol = 12 oz beer, 6 oz wine, 3 oz fortified wine (e.g., T-Bird), 2 oz spirits (one cocktail).
    - Triggers: Common triggers for COD-related alcohol abuse include psychological stress, amelioration of anxiety, proximity to users, desire for companionship, self-destructive impulses, and avoidance of alcohol withdrawal symptoms.
    - Substance payment sources: Common payment sources for COD-related alcohol abuse include disability benefits, legal income/allowance, and supplies from friends.
    - Motivations for change: Common motivations for COD-related alcohol abuse include avoiding psychological and physical effects of withdrawal, improving quality of life, decreasing high-risk situations, and saving money.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related alcohol abuse include supplying alcohol or money for purchase, tolerating presence of alcohol in the residential setting, and using alcohol with client.
    - Adverse consequences to client of alcohol abuse: Common adverse consequences to clients from alcohol abuse include alcohol withdrawal, general health problems (especially liver disease), exacerbation of symptoms of mental disorder (anxiety, depression, psychosis), subacute/chronic cognitive impairment, impairment of productivity, impairment in ability to follow MI treatment regimen due to cognitive impairment or incapacitation, impairment of interpersonal relationships, stigmatization, financial distress, placement in high-risk situations, and interaction with prescribed medications via additive sedation or impairment in metabolism.
    - Current alcohol abuse treatments or self-help: Common treatment attempts in COD-related alcohol abuse include attempts to stop independently either through abrupt cessation or gradual reduction, participation in alcoholics anonymous, and substitution of other sedative/hypnotic medications.

2. **Treatment Planning:** Include alcohol abuse cessation in all treatment plans for individuals with co-ocurring alcohol abuse.
    - Alcohol abuse may be directly related to mental health problems through alcohol-induced exacerbation (or cause) of symptoms of mental health condition, alcohol-induced noncompliance with mental health treatment, and/or alcohol-induced adverse effects on treatment of mental health condition. It is therefore likely to be a focus of treatment in outpatient mental health clinics.
    - Treatment goals for COD-related alcohol abuse may include detoxification, decreased alcohol abuse, stabilization of personal network, decreasing

alcohol-related mental health problems, and/or increasing the safety of mental health interventions (e.g., medications)

3. **Counseling for COD-related alcohol abuse:**
    - ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
        - For COD-related alcohol abuse, this interpersonal relationship is compromised by therapist references, verbal or visual, to the therapist's own current use of alcohol, or by therapist use of derogatory references to individuals who struggle with alcohol abuse.
    - ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
        - Motivation often includes discussion of adverse health consequences to self (including hangovers, blackouts, injuries, gastric distress, withdrawal and seizures), victimization by others, and adverse consequences to others via driving accidents and/or loss of impulse control.
    - ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement
        - The past history of multiple failed attempts to stop alcohol abuse prior to successful alcohol abuse cessation in most individuals should be emphasized for clients who have attempted to stop abusing alcohol in the past.
    - ***Give directed feedback:***
        - Feedback for COD-related alcohol abuse should include assessment of triggers and discussion of general health risks to self and others, and economic costs.
    - ***Ask open-ended questions***
    - ***Show reflected listening***
    - ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related alcohol abuse information should include discussion of the general medical dangers of alcohol abuse, the exacerbation of symptoms of mental illness by alcohol, the effect of alcohol on metabolism of antipsychotic medications, the increase in risk of accident and impaired impulse control, advisability of eliminating alcohol from the immediate residential environment, and the likelihood that recovery from alcohol abuse is almost always predicated on complete cessation of alcohol use.
    - ***Give advice:*** COD-related alcohol abuse advice should be to attempt to stop the use of alcohol due to potential exacerbation of general health-related problems and mental problems, increased dangers from high-risk situations, financial cost, and potential effects of alcohol on metabolism of prescribed medications.
    - ***Review options:*** Consider participation in Alcoholics Anonymous, referrals to other alcohol abuse cessation programs, pharmacologic detoxification

regimens, use of disulfiram for relapse prevention or naltrexone to decrease craving.

- ***Instill responsibility.*** Emphasize the role of choice in avoiding immediate and long-term health consequences to self and to others via accidents.
- ***Elicited talk of decreasing alcohol abuse***
- ***Give alcohol abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related alcohol abuse should emphasize
    - Importance of alcohol abuse cessation to both client and loved ones
    - Decreasing triggers for client, including use of alcohol by associates, supplying alcohol, and tolerating alcohol use within residential setting.
    - Decreasing client access to alcohol through removing alcohol from residential setting should be emphasized.
    - Decreasing contingency reinforcement of alcohol abuse, including supplying companionship during alcohol activities.
    - Decreasing other forms of enabling, including funding of alcohol purchases and inappropriately shielding client from legal or interpersonal consequences of alcohol abuse.
    - Give Alanon literature and contact information

5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, and avoidance of high-health risk activities Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** Stop benzodiazepine use. Consider divalproate for detoxification, disulfiram for relapse prevention, and naltrexone and/or topiramate for anticraving treatment.
7. **Ongoing assessment:** Elicit information on alcohol cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on available alcoholics anonymous programs (especially those with dual-diagnosis focus) and other alcohol abuse cessation programs.
9. **Documentation:** Program review should include chart review for presence of above

Marijuana > one or more marijuana cigarettes/day

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document average number of marijuana cigarettes used per day.
    - Triggers: Common triggers for COD-related marijuana abuse include psychological stress, amelioration of anxiety, proximity to users, desire for companionship, and desire to defy others.
    - Substance payment sources: Common payment sources for COD-related marijuana abuse include disability benefits, legal income/allowance, and supplies from friends.
    - Motivations for change: Common motivations for COD-related marijuana abuse include improving quality of life, decreasing high-risk situations, and saving money.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related marijuana abuse include supplying marijuana or money for purchase, tolerating presence of marijuana in the residential setting, and using marijuana with client.
    - Adverse consequences to client of marijuana abuse: Common adverse consequences to clients from marijuana abuse include exacerbation of symptoms of mental disorders (anxiety, depression, psychosis), subacute/chronic cognitive impairment, impairment of productivity, impairment in ability to follow MI treatment regimen due to cognitive impairment or incapacitation, impairment of interpersonal relationships, stigmatization, financial distress, legal consequences, and placement in high-risk situations.
    - Current marijuana abuse treatments or self-help: Common treatment attempts in COD-related marijuana abuse include attempts to stop independently either through sudden cessation or gradual reduction.

2. **Treatment Planning:** Include marijuana abuse cessation in all treatment plans for individuals with co-ocurring marijuana abuse.
    - Marijuana abuse may be directly related to mental health problems through marijuana-induced exacerbation (or cause) of symptoms of mental health condition, marijuana-induced noncompliance with mental health treatment, and/or marijuana-induced adverse effects on treatment of mental health condition. It is therefore likely to be a focus of treatment in outpatient mental health clinics.
    - Treatment goals for COD-related marijuana abuse may commonly include decreased marijuana abuse and decreasing marijuana-related mental health problems.

3. **Counseling for COD-related marijuana abuse:**

- ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
    - For COD-related marijuana abuse, this interpersonal relationship is compromised by therapist references, verbal or visual, to the therapist's own current use of marijuana, or by therapist use of derogatory references to individuals who struggle with marijuana abuse.
- ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
    - Motivation often includes discussion of adverse health consequences to self (including intoxication-related injuries, lung problems, and cognitive impairment), victimization by others, legal problems, and adverse consequences to others via driving accidents and/or loss of impulse control.
- ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement.
    - The past history of multiple failed attempts to stop marijuana abuse prior to successful marijuana abuse cessation in most individuals should be emphasized for clients who have attempted to stop abusing marijuana in the past.
- ***Give directed feedback:***
    - Feedback for COD-related marijuana abuse should include assessment of triggers and discussion of general health risks and mental health risks, legal risks, and economic costs.
- ***Ask open-ended questions***
- ***Show reflected listening***
- ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related marijuana abuse information should include discussion of the general medical dangers of marijuana abuse, the exacerbation of symptoms of mental illness by marijuana, the increase in risk of accident and impaired impulse control, advisability of eliminating marijuana from the immediate residential environment.
- ***Give advice:*** COD-related marijuana abuse advice should be to attempt to stop the use of marijuana due to potential exacerbation of general health-related problems and mental problems, increased dangers from high-risk situations, financial cost, and legal dangers.
- ***Review options:*** Referrals to self-help groups other marijuana abuse cessation programs.
- ***Instill responsibility.*** Emphasize the role of choice in avoiding immediate and long-term health, mental health, and legal consequences to self and others.
- ***Elicited talk of decreasing marijuana abuse***
- ***Give marijuana abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related marijuana abuse should emphasize

- Importance of marijuana abuse cessation to both client and loved ones
- Decreasing triggers for client, including use of marijuana by associates, supplying marijuana, and tolerating marijuana use within residential setting.
- Decreasing client access to marijuana. Removing marijuana from residential setting should be emphasized.
- Decreasing contingency reinforcement of marijuana abuse, including supplying companionship during marijuana-related activities.
- Decreasing other forms of enabling, including funding of marijuana purchases and inappropriately shielding client from legal or interpersonal consequences of marijuana abuse.
- Give Alanon literature and contact information

5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** N/A.
7. **Ongoing assessment:** Elicit information on marijuana cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on available marijuana cessation programs (especially those with dual-diagnosis focus).
9. **Documentation:** Program review should include chart review for presence of above

Inhalants > experimental use

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document type of inhalants used and frequency of inhalant abuse.
    - Triggers: Common triggers for COD-related inhalant abuse include psychological stress, amelioration of anxiety, proximity to users, desire for companionship, and desire to defy/anger others.
    - Substance payment sources: Common payment sources for COD-related inhalant abuse include legal income/allowance, supplies from friends, and stealing/shoplifting.
    - Motivations for change: Common motivations for COD-related inhalant abuse include, improving quality of life, improving interpersonal relationships, and decreasing high-risk situations.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related inhalant abuse include lack of awareness of abuse and minimizing consequences of abuse.
    - Adverse consequences to client of inhalant abuse: Common adverse consequences to clients from inhalant abuse include liver disease, exacerbation of symptoms of mental disorder (anxiety, depression, mood-instability, psychosis), subacute/chronic cognitive impairment, impairment of productivity, impairment in ability to follow MI treatment regimen due to cognitive impairment or incapacitation, impairment of interpersonal relationships, placement in high-risk situations, and interaction with prescribed medications via impairment in metabolism.
    - Current inhalant abuse treatments or self-help: Common treatment attempts in COD-related alcohol abuse include attempts to stop independently through abrupt cessation, or substitution of alcohol or other sedative/hypnotic medications.

2. **Treatment Planning:** Include inhalant abuse cessation in all treatment plans for individuals with co-ocurring inhalant abuse.
    - Inhalant abuse may be directly related to mental health problems through inhalant-induced exacerbation (or cause) of symptoms of mental health condition, inhalant-induced noncompliance with mental health treatment, and/or inhalant-induced adverse effects on treatment of mental health condition. It is therefore likely to be a focus of treatment in outpatient mental health clinics.
    - Treatment goals for COD-related inhalant abuse may include cessation of inhalant abuse, stabilization of personal network, decreasing inhalant-related mental health problems, and/or increasing the safety of mental health interventions (e.g., medications)

3. **Counseling for COD-related inhalant abuse:**

- ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
    - For COD-related inhalant abuse, the interpersonal relationship is enhanced by therapist projection of confidence in client's ability to stop using inhalants and focus on acute danger to the liver and central nervous system of continued use.
- ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
    - Motivation often includes discussion of adverse health consequences to self (including hangovers, blackouts, injuries, liver damage, and seizures), victimization by others, and adverse consequences to others via driving accidents and/or loss of impulse control.
- ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement
    - The ability of most individuals to stop inhalant abuse once they have been informed of the serious risks to health should be emphasized.
- ***Give directed feedback:***
    - Feedback for COD-related inhalant abuse should include assessment of triggers and focused discussion of severe risk of liver disease and irreversible cognitive damage.
- ***Ask open-ended questions***
- ***Show reflected listening***
- ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related inhalant abuse information should include discussion of the general medical dangers of inhalant abuse, the exacerbation of symptoms of mental illness by inhalants, the damage done by inhalants to cognitive abilities, the increase in risk of accident and impaired impulse control, and the advisability avoiding contact with others who are still using inhalants.
- ***Give advice:*** COD-related inhalant abuse advice should be to attempt to immediately stop the use of inhalants due to potential liver and CNS damage, exacerbation of mental problems, increased dangers from high-risk situations, and potential effects of inhalants on metabolism of prescribed medications.
- ***Review options:*** Consider participation in inhalant abuse cessation programs.
- ***Instill responsibility.*** Emphasize the role of choice in avoiding immediate and long-term health consequences to self and to others via accidents.
- ***Elicited talk of stopping inhalant abuse***
- ***Give inhalant abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related inhalant abuse should emphasize
    - Importance of inhalant abuse cessation to both client and loved ones
    - Recognition of inhalants in client's possession: gasoline, glue, nail polish, and aerosols.
    - Detection of inhalant odors in household.

- Decreasing triggers for client, including use of inhalants and tolerating the presence inhalants within residential setting.
- Decreasing client access to inhalants though removing inhalants from residential setting should be emphasized.
- Decreasing other forms of enabling, including inappropriately shielding client from legal or interpersonal consequences of inhalant abuse.
- Give Alanon literature and contact information

5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** Stop benzodiazepine use. Consider discontinuation of other psychiatric medications until inhalant abuse ceases.
7. **Ongoing assessment:** Elicit information on inhalant cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on inhalant abuse cessation programs.
9. **Documentation:** Program review should include chart review for presence of above

Psychostimulants (More than sporadic [average > 1x/week] use of cocaine, amphetamines, methylphenidate)

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document type of psychostimulants used and frequency of psychostimulant abuse.
    - Triggers: Common triggers for COD-related psychostimulant abuse include psychological stress, amelioration of depression or fatigue, proximity to users, desire for companionship, and avoidance of psychostimulant withdrawal symptoms.
    - Substance payment sources: Common payment sources for COD-related psychostimulant abuse include disability benefits, high-risk sexual activities, friends/family members, legal occupational income/allowance, savings, sales of personal property (including medications), and stealing/robbery.
    - Motivations for change: Common motivations for COD-related psychostimulant abuse include avoiding undesired psychological effects (especially anxiety, insomnia, and psychosis), avoiding undesired physical effects (especially anorexia and cardiac problems), improving quality of life, avoiding medical consequences, avoiding legal consequences, avoiding high-risk situations, and saving money.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related psychostimulant abuse include supplying money for purchase of psychostimulants, being unaware of psychostimulant abuse, or shielding client from the consequences of abuse.
    - Adverse consequences to client of psychostimulant abuse: Common adverse consequences to clients from psychostimulant abuse include psychostimulant withdrawal, general health problems (especially malnutrition and poor hygiene), exacerbation of symptoms of mental disorder (anxiety, depression, psychosis), impairment of productivity, impairment in ability to follow MI treatment regimen due incapacitation, impairment of interpersonal relationships, stigmatization, financial distress, placement in high-risk situations, and interaction with prescribed medications via impairment in metabolism.
    - Current psychostimulant abuse treatments or self-help: Common treatment attempts in COD-related psychostimulant abuse include attempts to stop independently either through abrupt cessation or gradual reduction and participation in 12-step programs.

2. **Treatment Planning:** Include psychostimulant abuse cessation in all treatment plans for individuals with co-ocurring psychostimulant abuse.
    - Psychostimulant abuse may be directly related to mental health problems through psychostimulant-induced exacerbation (or cause) of symptoms of mental health condition, psychostimulant-induced noncompliance with mental

health treatment, and/or psychostimulant-induced adverse effects on treatment of mental health condition. It is therefore likely to be a focus of treatment in outpatient mental health clinics.

- Treatment goals for COD-related psychostimulant abuse may include detoxification, decreased psychostimulant abuse, stabilization of personal network, decreasing psychostimulant-related mental health problems, and/or increasing the safety of mental health interventions (e.g., medications)

3. **Counseling for COD-related psychostimulant abuse:**
    - ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
        - For COD-related psychostimulant abuse, the interpersonal relationship is enhanced by therapist projection of confidence in client's ability to stop using psychostimulants, a focus on the impact of psychostimulants on the client's quality of life.
    - ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
        - Motivation often includes discussion of adverse consequences including exacerbation of symptoms of mental disorders (anxiety, depression, psychosis), general health problems (especially malnutrition and poor hygiene), impairment of productivity, impairment of interpersonal relationships, financial distress, placement in high-risk situations, adverse health consequences (including malnutrition, infections, mucous membrane deterioration, cardiac problems), and victimization by others.
    - ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement
        - The past history of multiple failed attempts to stop psychostimulant abuse prior to successful psychostimulant abuse cessation in most individuals should be emphasized for clients who have attempted to stop abusing psychostimulants in the past.
    - ***Give directed feedback:***
        - Feedback for COD-related psychostimulant abuse should include assessment of triggers (especially withdrawal) discussion of general health risks and legal risks, and economic costs.
    - ***Ask open-ended questions***
    - ***Show reflected listening***
    - ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related psychostimulant abuse information should include discussion of the general medical dangers of psychostimulant abuse (cardiovascular collapse), the exacerbation of symptoms of mental illness by psychostimulant abuse (anxiety, depression, and psychosis), and the significant dangers of violence and victimization associated with procurement of psychostimulants.

- ***Give advice:*** COD-related psychostimulant abuse advice should be to attempt to stop the use of psychostimulant due to potential exacerbation of general health-related problems and mental problems, increased dangers from high-risk situations, financial cost, and potential effects of psychostimulants on metabolism of prescribed medications.
- ***Review options:*** Suggest participation in psychostimulant abuse cessation programs and consider pharmacologic detoxification regimens.
- ***Instill responsibility.*** Emphasize the role of choice in avoiding immediate and long-term health consequences.
- ***Elicited talk of decreasing psychostimulant use***
- ***Give psychostimulant abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related psychostimulant abuse should emphasize
    - Importance of psychostimulant abuse cessation to both client and loved ones
    - Decreasing triggers for client, including use of psychostimulants by associates, supplying psychostimulants, and tolerating psychostimulant use within residential setting.
    - Decreasing client access to psychostimulants through removing psychostimulants and paraphernalia from residential setting should be emphasized.
    - Decreasing contingency reinforcement of psychostimulant abuse, including supplying companionship during psychostimulant abuse-related activities.
    - Decreasing other forms of enabling, including funding of psychostimulant purchases and inappropriately shielding client from legal or interpersonal consequences of psychostimulant abuse.
    - Give Alanon literature and contact information

5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:** Consider short-term use of benzodiazepines during acute psychostimulant withdrawal. Consider use of antidepressants to improve depression and reduce craving during prolonged psychostimulant withdrawal.
7. **Ongoing assessment:** Elicit information on psychostimulant cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on NA and other available psychostimulant abuse cessation programs (especially those with dual-diagnosis focus).
9. **Documentation:** Program review should include chart review for presence of above.

Opioids (Any use of heroin, any misuse of opioid medications)

1. **Initial Assessment:** Document the following in narrative and using standard assessment form:
    - Abused substances: Document type of opioid(s) used and frequency of opioid abuse.
    - Triggers: Common triggers for COD-related opioid abuse include proximity to users, desire for companionship, and avoidance of opioid withdrawal symptoms.
    - Substance payment sources: Common payment sources for COD-related opioid abuse include high-risk sexual activities, friends/family members, legal occupational income/allowance, savings, sales of personal property (including medications), and stealing/robbery.
    - Motivations for change: Common motivations for COD-related opioid abuse include avoidance of psychological and physical consequences of withdrawal, improving quality of life, avoiding medical consequences (blood-borne infections, accidental overdose), avoiding legal consequences, avoiding high-risk situations, and saving money.
    - Caregiver/spousal roles in substance abuse: Common caregiver/spousal roles in COD-related opioid abuse include supplying money for purchase of opioids, co-abuse of opioids, or shielding client from the consequences of abuse.
    - Adverse consequences to client of opioid abuse: Common adverse consequences to clients from opioid abuse include opioid withdrawal, general health problems (especially Hepatitis B and C, human immunodeficiency virus [HIV], and subacute bacterial endocarditis [SBE]), exacerbation of symptoms of mental disorder (anxiety and depression), impairment of productivity, impairment in ability to follow MI treatment regimen due incapacitation, impairment of interpersonal relationships, stigmatization, financial distress, placement in high-risk situations.
    - Current opioid abuse treatments or self-help: Common treatment attempts in COD-related opioid abuse include attempts to stop independently through abrupt cessation and participation in 12-step programs.

2. **Treatment Planning:** Include opioid abuse cessation in all treatment plans for individuals with co-ocurring opioid abuse.
    - Opioid abuse may be directly related to mental health problems through opioid-induced exacerbation (or cause) of symptoms of mental health condition, opioid-induced noncompliance with mental health treatment, and/or opioid-induced adverse effects on treatment of mental health condition. It is therefore likely to be a focus of treatment in outpatient mental health clinics.
    - Treatment goals for COD-related opioid abuse may include detoxification, decreased opioid abuse, stabilization of personal network, decreasing opioid-related mental health problems.

3. **Counseling for COD-related opioid abuse:**
    - ***Provide interpersonal relationship that fosters trust, confidence, and focus:*** using empathy, respect, accepting ambivalence, single topic of substance use.
        - For COD-related opioid abuse, the interpersonal relationship is enhanced by therapist projection of confidence in client's ability to stop using opioids, a focus on the impact of opioids on the client's quality of life.
        - The interpersonal relationship is compromised by therapist use of derogatory references to individuals who struggle with opioid abuse.
    - ***Enhance motivation during interview through review and discussion of adverse consequences and specific motivations for change (include individualized assessment results)***
        - Motivation for opioid abuse cessation often include avoidance of undesired psychological and physical effects of withdrawal, improved quality of life, improve ability to adhere to MI treatment regimen, improve interpersonal relationships, avoidance medical consequences, avoidance of legal consequences, avoidance of high-risk situations, and saving money.
        - Motivation often includes discussion of adverse consequences including exacerbation of symptoms of mental disorder during withdrawal, impairment of productivity, impairment in ability to follow MI treatment regimen, impairment of interpersonal relationships, stigmatization, financial distress, and placement in high-risk situations (especially risks of victimization and exposure to blood-borne pathogens).
    - ***Show therapist optimism and affirmation:*** stories of treatment success, encouragement
        - The past history of multiple failed attempts to stop opioid abuse prior to successful opioid abuse cessation in most individuals should be emphasized for clients who have attempted to stop abusing opioids in the past.
    - ***Give directed feedback:***
        - Feedback for COD-related opioid abuse should include assessment of triggers (especially withdrawal) discussion of general health risks (HIV, Hepatitis B and C, and SBE) and legal risks, and economic costs.
    - ***Ask open-ended questions***
    - ***Show reflected listening***
    - ***Give information about substance abuse patterns and treatment principles of treatment.*** COD-related opioid abuse information should include discussion of the importance of avoiding triggers that lead to renewed opioid addiction, the significant medical dangers of opioid abuse (blood-borne infections and accidental overdose), and the significant dangers of violence and victimization associated with procurement of opioids.
    - ***Give advice:***

    - COD-related opioid abuse advice should be to attempt to stop the use of opioid due to risk of general health-related problems (HIV, hepatitis B and C, SBE) and mental problems during withdrawal, dangers from high-risk situations, interpersonal consequences, and financial cost.
    - Opioid users should also be instructed to avoid the use of potentially contaminated needles and syringes, avoid
- ***Review options:*** Suggest participation in Narcotics Anonymous and other opioid abuse cessation programs and consider pharmacologic detoxification regimens.
- ***Instill responsibility.*** Emphasize the role of choice in avoiding immediate and long-term health consequences.
- ***Elicited talk of decreasing opioid use***
- ***Give opioid abuse literature***.

4. **Counsel caregivers and family:** Counseling for COD-related opioid abuse should emphasize
    - Importance of opioid abuse cessation to both client and loved ones
    - Decreasing triggers for client, including use of opioids by associates, supplying opioids, and tolerating opioid use within the residential setting.
    - Decreasing client access to opioids through removing opioids and paraphernalia from residential setting should be emphasized.
    - Decreasing contingency reinforcement of opioid abuse, including supplying companionship during opioid abuse-related activities.
    - Decreasing other forms of enabling, including funding of opioid purchases and inappropriately shielding client from legal or interpersonal consequences of opioid abuse.
    - Give Alanon literature and contact information
    - Notify suppliers (physicians, pharmacists) of medical opioids and benzodiazepines.
5. **Healthy living groups**: Enroll all abusers in all clinics. Include counseling about diet, exercise, good lifestyle choices, productive use of time, and avoidance of high-health risk activities.
6. **Pharmacological intervention:**
    - Consider short-term use of benzodiazepines or substitution of decreasing doses oral opioids and clonidine during acute opioid withdrawal.
    - Determine need for inpatient detoxification as setting for interventions.
    - Consider naltrexone as longer-term anticraving intervention
    - Stop prescription of opioids for subjective pain complaints and notify other prescribers.
7. **Ongoing assessment:** Elicit information on opioid cravings, last use, amount of use, and stage of readiness on monthly basis.
8. **Link to mutual-help and recovery programs:** All clients and caregivers are linked should be given information on NA and other available opioid abuse cessation programs (especially those with dual-diagnosis focus).
9. **Documentation:** Program review should include chart review for presence of above.

Other Abused Substances: Use general module and modify as appropriate.

Polysubstance abuse: Special attention to medical complications

Special populations: Kids, Older Adults

Resources:

http://www.health.org/
http://www.csat.org/ Tip: Motivational enhancement
http://www.motivationalinterviewing.org/
http://www.samsha.gov/ treatment strategies for COD
http://www.tobaccoprogram.org/